TESTIMONY OF ALAN H. KOSBERG

First I wanted to apologize for not being at the hearing in person. However, the constraints of a brand new employment situation make that impossible.

I further understand that many others who have regularly appeared at the large number of hearings on matters affecting the ABI Waiver are – through an unfortunate alignment of stars – also not able to attend either - some for serious personal and family medical issues.

However and importantly, I did not want my not being there personally to testify – - or the odd alignment of stars that has resulted in the unavailability of others to offer a voice on the matter – to in any way diminish the seriousness and importance with which I (and I know others) view the issues before the committees today. Your actions today have extraordinarily important repercussions for all families involved in the Waiver program . . . and thank you for your consideration of these issues.

I offer not only testimony today . . . but, and perhaps as importantly, **QUESTIONS which you may want to direct to DSS and which may help and inform you as you deliberate over these important issues**. The questions directly are integrated into my comments on the following pages.

SUMMARY

I offer testimony with respect to three items:

Issue #1. First and foremost, DSS has announced in provider meetings and often repeated in direct conversations and in the press that DSS is refusing to process people on the waitlist for ABI Waiver services UNLESS and UNTIL the legislature approves private case management.

THIS IS PURE AND SIMPLE EXTORTION.

And the slippery slope it conjures up is shocking . . .

The LEGISLATURE SHOULD **NOT ENTERTAIN ANY PROPOSAL** FROM DSS UNTIL DSS UNEQUIVOCALLY **AND UNCONDITIONALLY** COMMITS TO AND **ACTUALLY DOES DO** THE WORK THEY ARE MANDATED TO DO.

YOU SHOULD – AND YOU SHOULD FORCE DSS TO - DISCONNECT, DISENGAGE, AND SEPARATE the ideas of DSS: (i) Doing their job; from (ii) Your approval of private case management.

These are TWO separate ideas and one should not be conditioned on the other.

Issue #2. **THE EVIDENCE DSS OFFERS** IN SUPPORT OF PRIVATE CASE MANAGEMENT **IS NOT SUBSTANTIAL OR PERSUASIVE** AND **SHOULD BE DISCOUNTED IF NOT WHOLLY DISREGARDED**

I anticipate that the evidence DSS will offer primarily on 4 elements, each of which I discuss – and ask you to ask questions about – in the following pages

(a) The survey of ABI Clients in the Pilot program;
(b) The numbers (THE OPM SCORING)
- *In particular, the OPM Scoring is flawed and misleading.* See in particular, the comparison made of 20 Full Time DSS workers to (a mere) 6220 hours for privatized case management;
IS DSS/OPM comparing "apples to apples" ??
NOTE: 17 full time social workers work in excess of 30,000 hours. See other questions listed on page 14 below.

(c) Testimony of DSS; and
(d) Testimony from entities formerly opposed to it and now for it – i.e. BIAC.

Issue #3. The CASE FOR PRIVATE CASE MANAGEMENT ITSELF.

The heart of the matter before you.

We should NOT lose track of the fact that at issue is **ROUGHLY ¾ OF A MILLION DOLLARS** (and only marginally more in the succeeding two years).

This is the amount - according to the OPM scoring – that the State would save by privatizing case management. *While not insubstantial, it also should not be a "budget buster".* HOWEVER and MORE IMPORTANTLY, I BELIEVE THAT THERE ARE COSTS OF SUCH A SWITCH **THAT ARE NOT INCLUDED IN AND ACCOUNTED FOR BY OPM'S SCORING** that **make privatizing case management a FAR MORE COSTLY alternative for the State**.

More importantly, by proposing to privatize case management, DSS undermines the ABI Waiver program **by diluting the resources supporting, overseeing and administering each ABI Waiver Plan.**

Compounding this, is that the very manner of achieving DSS's goal is through installing service providers whose first priority is profit . . . and only secondarily on improving care.

Compounding this still further is the sense that – even if private case management is a viable alternative (which I am dubious about), the method and structure of such a plan as outlined in the RFP **FAILS TO CONSIDER AND/OR BUILD IN** necessary and obvious safeguards to protect the quality of care required to be delivered – ***such items include, but are not limited: (a) the safe scale ability from 0 cases to more than 518 across the State, (b) the provisions for sufficient case management hours to do what is needed (the current proposal only allows for 12 per client per year); (c) provisions limiting the case manager/client ratio to a manageable number; and (d) the credentials and experience of the actual case managers as opposed to the care management agency for whom they would work (DSS stumbled over this and was ambiguous at the last hearing).***

We in the ABI Waiver Community have experience with privatization already - - the fiduciary Allied Resources. Our own experience tells us that this alternative is inefficient, unwieldy and or provides poorer service. Allied is renowned for losing paperwork, forcing providers to do and redo paperwork, and, at times, is so poor, that DSS social workers themselves are required to intercede just to get things done. We fear that same level of service will also characterize this new private enterprise.

As importantly, DSS, by moving from directly administering to indirectly administering the Waiver program, is more removed (and is moving in the opposite direction) from the kind of oversight necessary to IMPROVE the level of care delivered to persons with Acquired Brain Injury.

I say that with some trepidation as, as you know, many of us in the ABI Waiver Community feel that DSS /OPM is antagonistic towards the program and us. . . . as is evidenced, in part, by past hearings and the way they have administered the program.

Nonetheless . . . . DSS asks you to believe – and has with every proposal put before you - that somehow they can do something magical – that they can get something cheaper and get better quality.

DSS's frequent and continued reliance on this argument in a backhanded way should call into question their very own ability to run a program and the thought and care they give to administering it.

But more fundamentally, IT STRAINS CREDIBILITY AND STRAINS EACH OF OUR FUNDAMENTAL UNDERSTANDING OF THE TRUISM: "*YOU GET WHAT YOU PAY FOR*" . . . . . for DSS is asking, once again, that you believe that the State can get more and better service for cheaper dollars.

AS WRITTEN, THE RFP AND DSS'S PLAN DOES NOT ASSURE THAT ABI PARTICIPANTS WILL RECEIVE GOOD QUALITY CASE MANAGEMENT SERVICES IN A SUFFICIENT AMOUNT AND FROM PEOPLE QUALIFIED TO PROVIDE IT.

Further, the OPM scoring is not a comparison of "apples to apples" (and is itself flawed as indicated below). IN SHORT, THE SAVINGS TO THE STATE ARE NOT A LITTLE MORE THAN ¾ OF A MILLION DOLLARS AS OPM WOULD HAVE YOU BELIEVE – THE COSTS TO ABI WAIVER PARTICIPANTS FAR EXCEEDS THESE DOLLARS.

This leaves me in the awkward position of having to choose between: (i) privatization – which I think is a bad idea in the long run; and (ii) remaining directly under the auspices of DSS, which I believe has demonstrated a degree of antagonism and lack of true, heartfelt understanding of the issues surrounding the ABI Waiver Program.

Ultimately however, I fail to see how the program can improve with its ultimate oversight yet another step removed from the day to day experiences that those with acquired brain injury face each day, and believe that the privatization plan - as now described in the RFP - will lead to an even more perilous outcome and continue the downward spiral in the quality of care provided through this waiver to people with an acquired brain injury

For that reason, I oppose the plan for privatization.

MORE DETAILED COMMENTS

I. DSS SHOULD DO THE WORK THEY ARE MANDATED TO DO **UNCONDITIONALLY;** THAT IS, your approval of privatization of case management services **SHOULD NOT BE A CONDITION** to their processing people off the waitlist; to DSS doing their job.

DSS's refusal to process applications absent your approval of private case management is EXTORTION . . . . and is a scary slippery slope.

DSS has stated and often-repeated that they will not process **ANY** additional waiver applicants off the waitlist unless and until private case management is approved by the legislature . . . . **and even then, DSS hedges in their commitment to add new people** from the Waiver List – only saying that they will "begin to consider . . . " or weasily words of similar affect.

THE LEGISLATURE SHOULD NOT ALLOW THIS TO CONTINUE.

DSS offers the same "we don't have resources excuse" to justify this unprecedented action.

At the outset, even attempting to refute DSS's assertion *implicitly suggests that this may be a valid argument for not doing their job. IT IS NOT!*

However, and at the risk of going down this "rabbit-hole", **DSS's own words and actions DEMONSTRATE that this defense is PRETEXTUAL.**

THAT IS *and by its own statements and actions* has shown that:

1. **DSS does have the resources to process applications and has demonstrated its ability to do so; *[See Questions to Ask Below]***

2. **DSS has offered conditions upon which DSS could process applications WHICH HAVE BEEN MET** . . . . *though DSS still refuses to process applications*; and ***[See Exhibit A attached and Questions to Ask Below]***

3. **DSS "Cherry Picks"** the cases that will result in an immediate savings to the State (and drags their feet on others) by adding to the Waiver a **disproportionate** number of MFP (Money Follows the Person) Cases. DSS's ability to do this evidences their

ability to address people on the Waiver – should they want to do so ***[See Questions to Ask Below]***

Aside: This "Cherry-Picking" IS A FORM OF DISCRIMINATION WHICH SHOULD BE STOPPED.

Moreover, more importantly THE BENEFIT TO THE STATE ON MONEY FOLLOWS THE PERSON PLANS (change for 100% State funding to 50% State/50% Federal funding) ***CREATES DOLLARS that can be and should be rededicated/applied to those who have been on the wait list for years and were "passed over" when Waiver II was created***

A. QUESTIONS ELICITING THE FACT THAT DSS HAS THE RESOURCES TO PROCESS APPLICATIONS AND HAS DEMONSTRATED ITS ABILITY TO DO SO

1. How many people have been added to ABI Waiver II in Waiver year 2 (since December 2015) ?
2. How many other applications are in some stage of processing? What are those various stages of processing and how many applicants are currently in those stages?
3. How many people were added to the Waiver II in the 30, 60, 90 days prior to the last hearing at which privatization was denied by the legislature?
4. How many applications were processed during the 30, 60, 90 days prior to the last hearing at which privatization was denied by the legislature?
5. What are the steps for processing?
6. What are the time periods for processing?
7. How much time is required for each step?
8. What resources are required of DSS to process an application?
9. Are there people who are at the stages of approval which require little/minimal DSS resources whose applications are being held up by DSS's refusal to continue processing applications?

    i.e. Carol Alpert – whose PLAN WAS APPROVED and was told just days before the last legislative hearing and that her daughter would be added to the Waiver only to have DSS renege on that promise when the legislature denied privatizing case management earlier.

10. If resources are not available, where else have they been redeployed?
11. If privatization is approved, **how soon and at what rate** will people on the waitlist be added to the Waiver? What assumptions if any are built into that? Is this a promise from DSS and the State?.
12. Does DSS continue to process the Money Follow the Person applicants and add them to the Waiver?
    a. If so, why is it only processing the ones that save the State money and why isn't it processing the ones who have the need and who have waited for years??
    b. If not, why not?
13. Is DSS processing DHMAS cases?
    a. If so, how and why?
    b. If not, why not?
14. To the extent DSS processed and/or processes MFP Cases, **WHY CAN'T THE MONEY RECEIVED THROUGH FEDERAL REIMBURSEMENT BE USED TO FUND the 13 CASES CURRENTLY ON THE WAITLIST??**

Conclusion: I believe that the answers to these questions will demonstrate that DSS can process applications to the Waiver program if it so choose to do.

B. **QUESTIONS REGARDING CONDITIONS UPON WHICH DSS STATED THAT IT COULD PROCESS APPLICATIONS - WHICH HAVE SINCE BEEN MET -** THOUGH DSS STILL CONTINUES TO REFUSE TO PROCESS APPLICATIONS.

DSS at first stated that it could not add people to Waiver 2 who waiting for the slots not otherwise reserved for MFP or DHMAS clients UNLESS there was attrition from Waiver I. There HAS BEEN attrition from Waiver I, yet the slots remain unfilled.

Aside: THE ABI WAIVER COMMUNITY STRONGLY DISAGREES THAT [CERTAIN??] WAIVER SLOTS ARE RESERVED FOR PEOPLE WHO CAN ONLY BE ADDED TO ABI WAIVER II UPON ATTRITION FROM ABI WAIVER I.

QUESTIONS TO ASK:

1. Is it a condition to filling available slots from the Waitlist that there be attrition from the ABI Waiver I?

    a. If so, where does this authority emanate from?
    b. If not, why did DSS say this?
        i. Was it a pretextual reason to simply deny adding people to the Waiver?
    c. Does it apply equally to all waiver slots or only the one not reserved for DHMAS or MFP clients.
2. How much attrition has there been from ABI Waiver I (we understand at least 2-3 slots)?
3. Has DSS moved to fill the slots made available through attrition on ABI Waiver I?
    a. If so, what have they done?
    b. If not, why not? Why can't those resources that were devoted to the those no longer on the Plan be rededicated to fill at least some of the 13 slots NOT reserved for DHMAS or MFP Clients??

Conclusions: The reasons offered by DSS for lack of action are pretextual.

C. Questions Regarding DSS's DISCRIMINATORY HANDLING OF THE WAITLIST

ABI Waiver II set aside waiver slots for people who were already receiving services that were 100% paid for by the State. Through the Waiver, the State sought to recoup 50% of those costs through Federal reimbursement through Money Follows The Person program,. Accordingly, for that subset of eligible citizens, Waiver II saved the State money.

Under Waiver II, a **disproportionately high number** of slots were created AND RESERVED specifically for MFP-eligible persons.

However, and at the same time, a much smaller number of slots remained available for people who were already in the community (through the support of their families or others and/or who were underserved by the services they were receiving from the State THOUGH THEY QUALIFIED FOR ABI WAIVER SERVICES)

In essence, a disproportionately high number of those waiver cases that saved the State money were "brought to the front of the line" while the State paid "lip-service" to the rest by only reserving a much smaller number of slots for them

THIS IS DISCIMINATORY!!

Questions to Ask DSS:

1. How many slots were created by Waiver II?
2. How many slots were reserved for people MFP-eligible people? For DHMAS cases? For the Non-MFP, Non-DHMAS clients?
3. What percentage of the total slots available do the MFP slots represent? The DHMAS slots? The non-MFP, non-DHMAS Slots?
4. For each category, how many slots have been filled in ABI Waiver Year II? Is there a higher percentage of slots filled from any one category of eligible slots?
5. Do any category of slots currently have slots available for which there is no eligible client ready and approved to fill the Waiver slot?
6. For which slots are there cases that can be moved off the waitlist onto the Waiver?
7. Does DSS continue to process the Money Follow the Person applicants and add them to the Waiver? Does it do so for DHMAS clients?

Conclusions: *DSS's CLAIM OF ITS INABILITY TO SERVICE THE ABI WAIVER PLAN IS PRETEXTUAL . . . . DSS has processed a great number of cases already this year - including and leading up to the last hearing on privatization; DSS-stated conditions to processing applicants off the waitlist have been satisfied though applicants continue to linger on the waitlist; and DSS (likely) continues to process applicants and offer them spots on Waiver through Money-Follow-the-Person . . . . . thereby suggesting and evidencing that DSS's claim of lack of ability to add people to Waiver 2 from the Waitlist is pretextual.*

HOWEVER and REGARDLESS and MORE IMPORTANTLY, WHETHER DSS HAS THE RESOURCES TO PROCESS CLAIMS (and it does) IS NOT an APPROPRIATE INQUIRY.

DSS is mandated to DO THEIR JOB and they MUST DO IT . . . WITHOUT CONDITION.

II. THE EVIDENCE THAT DSS OFFERS IN SUPPORT OF PRIVATE CASE MANAGEMENT IS INSUBSTANTIAL AND UNPERSUASIVE AND SHOULD BE DISCOUNTED OR DISMISSED ENTIRELY.

I suspect that DSS will offer at least four items of evidence in support of privatizing case management:
(a)The survey of ABI Clients in the Pilot program;
(b) The numbers (THE OPM SCORING);
(c) Testimony of DSS; and
(d) Testimony from entities formerly opposed to it and now for it – i.e. BIAC.

Each is flawed as the following <u>questions</u> may help elicit:

A. The Survey.

We understand that the survey was of 38 people (a very small sample) . . . . . but more importantly was self-administered and reported by the entity that did the private case management in the Pilot program.

More specifically, they conducted a phone survey and asked respondents to rate their service.

QUESTIONS TO ASSIST YOU TO DETERMINE THE CREDIBILITY OF THE SURVEY:
What were the questions asked?
Who vetted the questions?
Why was the subject of the Pilot program conducting a study on itself?
What was the purpose of the study? Was it done to evidence the need for privatization?
Was it done at the direction of DSS? If not, then who? Why was it done?
How could the surveyors disclaim bias?
How accurately did the company report the answers?
Did they "shade" any answers in their own favor?
How do we know?
Were the surveyors themselves taking responses from the very clients who themselves brain injured and potentially less able to provide accurate information?
If the respondents were ABI Waiver recipients, how do we know that they were fully cognizant of the difficulties encountered and the improvement provided by private case

managers? That is, to what extent are/were they aware of the degree of support offered by their own families and friends?

Even assuming (A BIG ASSUMPTION) the results of the survey were accurate . . . .
Why was the Pilot program done in Danbury?
Were the services in Danbury more deficient/more needy than in other parts of the State?
That is were the conditions in Danbury such that any marginal improvement there be seen as a dramatic improvement?
Do all areas of the State have the same problems? (This would be hard to imagine)
If not, how can the survey provide any useful information about other areas of the State that do not have the same conditions as Danbury??

Conclusion: The survey is so flawed in terms of sample size, bias, appropriate administration, failure to account for differences in the underlying conditions in Danbury at the beginning and end of the Pilot program, etc., etc, etc., that the validity of it MUST BE DISCOUNTED.

B. The numbers / OPM's Scoring:

By the numbers, it appears that:

1. **518 ABI Plans (and growing) will be supervised and managed in 6220 hours per year. This amounts to 12 hours per client per year?!?!?!**

   How can the cases be adequately managed in 12 hours per year per client – ESPECIALLY by an entity that does not have the experience of existing DSS personnel??

2. By the same token, **if only 6220 hours are needed to handle 518 cases** (and growing) WHY does OPM Assume **that the work of 20 Full time DSS Staff could be replaced by private case management.**

   FYI - 17 (only) social workers working a 40 hours week for 48 weeks a year put in **32,640** hours . . . . which leaves us in the ABI community struggling to understand

3. By comparing 6220 hours to be provided by a private case management entity to the work of 17 social workers and 3 other DSS staff, **aren't we overcounting the cost of the DSS Workers (as they clearly work on other things other than ABI Waiver Cases**
   I.E.: THE NUMBERS ARE NOT AN "APPLES TO APPLES" COMPARISON IN AS MUCH AS IT INCLUDES THE ENTIRE WORK OF 20 DSS WORKERS WHEN ACTUALLY ONLY A PORTION OF THEIR WORK IS ON ABI WAIVER CASES

4. If the savings the State obtains is primarily a savings in the benefits it would pay, then the State must also assume that the same benefits WOULD NOT be available to the private case management providers – in which case, and by definition, you are likely to have far less compensated "professionals" performing the tasks previously done by DSS staff. [See adage regarding quality above – "**You get what you pay for**"]

5. Is BIAC's consulting services an element of OPM Scoring? How much is BIAC being paid for this service?

MOREOVER, The OPM Scoring DOES NOT TAKE INTO ACCOUNT:

(1) The destabilizing costs of replacing existing experienced case managers with new case managers lacking the same experience;
(2) The damages suffered in the transition itself;
(3) DSS being one-step removed from providing the kind of oversight that is necessary to IMPROVE the Plan.

Conclusion: The OPM Scoring is flawed and should be discounted if not dismissed altogether as evidence supporting DSS's claim that privatization will save the State money.

C. Testimony of Advocates who were once opposed to privatization and who are not for it.

Specifically, BIAC. We note that BIAC gets its funding from the State (and is a line item in DSS's budget) and will now be getting paid to provide training to whichever agency secured the contract (if privatization is approved) – AS AN ASIDE: WE ASSUME THE COSTS OF BIAC's TRAINING ARE NOT FILTERED INTO OPM's SCORING.

Accordingly, their testimony should be weighed with an understanding of their bias.

QUESTIONS TO ASK:

1. What is the source of BIAC's revenues?
2. How much do they received directly or indirectly from the State (including from motor vehicle tickets – which we understand they receive a portion of)?
3. How much is BIAC would BIAC get paid were privatization to pass the legislature and BIAC be hired as a consultant?
4. **At *proportion* of their annual budget to these sources of revenue constitute?**
5. What brain injury certificate/credential did BIAC testify to the last hearing (which they said wasn't even enough) and what has changed not in the RFP to temper the concerns they then had??

III. Privitizing Case Management

My comments are set forth in the Summary above.

QUESTIONS TO ASK:
How was the $250 per hour arrived at?
How does DSS suspect that this money will be allocated among the various reporting levels of any agency providing the case management services?
What are the difficulties in ramping up to 518 cases? How has DSS addressed these problems?
Why not try a test run it on a subset of all ABI Waiver cases to create a large sampling . . . and hopefully avoid the struggles engendered by such a large transition.
Shouldn't the case manager to ABI Waiver Plans ratio be stipulated so as to assure that each Plan gets an appropriate amount of attention? (and to temper any potential profit margin gained through spreading resources thinly)
Why does the RFP not stipulate a minimum or, more importantly, a maximum number of cases for each case manager?

In addition to my comments in the Summary section, these questions are important in determining whether any private agency can provide effective case management services AND NEEDS TO BE PART of THE RFP.

GRATUITOUS POSTSCRIPT

Despite the veneer layered on by DSS in each of its efforts, those of us in the brain injury community (and I trust most if not all of you) recognize that DSS (acting in concert with OPM) has been primarily (some might say exclusively) motivated by fiscal concerns not care issues . . . . and that the practical effect (again despite the veneer) of DSS's proposals and the effect of HOW DSS has overseen and implemented the Waiver has been a reduction and/or dilution of the resources supporting, overseeing and administering each ABI Waiver Plan . . . . **and ultimately less and poorer DIRECT care being delivered.**

Privatizing case management is a further step in this direction.

To digress and clarify for a moment – and as evidence of the quality of care issues here:

Families with loved ones on the Waiver are NOT seeking a "gold-plated" standard of care. We struggle, in my particular case and by example only – with:

(i) Caregivers who don't show up - sometimes with no notice and sometimes with as little as only 1-2 hours notice;

(ii) Caregivers who come in and sleep on the job (and tell my sister (and thereby putting her in awkward position between caregiver and family overseeing care)) to "not tell your mother that I slept";

(iii) A Caregiver who on several occasions allowed my sister to be victimized by "turning the other cheek" when a family member of the caregiver (who inexplicably was with the two of them) asked my sister for a "loan" so he could have lunch;

(iv) Another who took my sister out for dinner - allowed her to pay by credit card (and the bill included 3 alcoholic drinks – only one of which was for my sister (raising two separate issues as well)) and then convinced my sister that she didn't pay enough and needed to pay the bill a second time in cash as well;

(v) That same caregiver later stole a tablet and other items of personal property and has for 1 ½ years been providing court supervised restitution.

(vi) Agencies (we have had 5 over the past 2 ½ years) who don't have sufficient staff and can't keep them because of the low wages;

(vii) Agencies that demand that you entrust a large share or all of the "higher paying" hours in order to staff the lower hourly rate PCA and companion hours.

(viii) Caregivers who won't work an overnight shift even for $12.00 (the highest rate allowed if not an ILST) and ask that you supplement their wages "under the table."

I have heard of stories far worse than these – including horror stories of sexual abuse, being force fed dog food, having personal items stolen, and food disappearing from their refrigerators, among other things. **Families have been forced to put locks on freezers and closets in their loved ones house and install nanny-cams in an effort to protect their loved ones from the very caregivers they are forced to entrust their loved ones care to.**

Each agency here can also attest to the fact that turnover is among the highest of any occupation . . . . . because, after all, and given the system, you are asking some people to work for $10 or $12 for companion level services and - at least through an agency - perhaps as much as $16.00 for ILST services, and these employees are not given or paid for any training; it is their job to get the clients into the community and they may have to spend some of their own paycheck on the job (or not do their job); and all for a caregiving job which burdens them with care, safety and well-being of a behaviorally, cognitively and/or physically disabled person.

While many are well-meaning and responsible caregivers, agencies and my own experience tells me that the great majority of these people (by 2 separate agencies' estimate – as much as 80% of their staff) simply want a job, not necessarily *the* job.

We're not seeking "gold-plated" care . . . we're struggling to keep our loved ones from being victimized; we're seeking just a basic level of responsible care by people who are properly trained to administer it.

None of DSS's proposals address have addressed this fundamental issue of direct care.

EXHIBIT A

LETTER FROM COMMISSIONER BREMBY TO CTBISN/ELAINE BURNS

December 9, 2015

Dear Ms. Burns,

Thank you for your recent communication concerning the ABI Waiver II. The ABI Waiver II does not propose "jumping over" existing waiting lists. The waiver utilizes reserve capacity for persons transitioning from Money Follows the Person (MFP) program, or for persons served by the Department of Mental Health and Addiction Services (DMHAS) ABI program.

The reserve capacity was approved by the Centers for Medicare and Medicaid Services when they approved the waiver. This actually served the purpose of allowing people who did not fall into the reserve capacity categories to move up on the waiting list and be served sooner. ***[Emphasis added – at the expense of others on the Waitlist already].*** The department carefully monitors the waiting list to ensure that persons are served in the order in which they applied. The amended version of the waiver has 180 slots in year 2. Eighty-one (81) are reserved for MFP and 58 are reserved for DMHAS leaving available 41 slots for non MFP or DMHAS program participants. [***Alan Kosberg Note: NOTETHE DISPORPORTIONATE NUMBER OF SLOTS RESERVED TO MFP CLIENTS WHOSE TRANSITION TO THE WAIVER WOULD RESULT IN AN IMMEDIATE SAVINGS TO THE STATE THROUGH FEDERAL REIMBURSEMENT. Why can't the money saved by the State in these 81 MFP Slots be rededicated to filling the 13 slots described below????]***

Twenty-eight (28) of the 41 available slots were filled or at least obligated in waiver year 1 that ended 11/30/2015. That leaves 13 slots available for waiver year 2 that began 12/1/2015. When the budget was developed for the waiver, the underlying assumption was that approximately 13 persons would leave waiver 1 each year by attrition. **Since funding for waiver 2 is dependent upon waiver 1 attrition, there are no funds available to immediately utilize the 13 slots now identified as unfilled or designated in in waiver year 2 that began two days ago.** ***[Emphasis Added: In other words, DSS can fill slots reserved for MFP Cases or reserved for DHMAS Clients, BUT NOT for those non-MFP, NON-DHMAS who were on the waitlist for Waiver I before Waiver II was created.]*** Our plan is to assign these waiver year 2 slots over the course of the waiver year as resources become available.

Please feel free to contact me, or Kathy Bruni, should you have additional questions or wish to discuss this matter in further detail.

Respectfully,

Rod